

THINK PIECES

When comparison comes first: Reflections on theory in medical anthropology

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Abstract

This think piece draws on experiences of fieldwork in a Papua New Guinean hospital to reflect on tensions between political engagement and ‘deep’ comparison in medical anthropology theory. The paper argues that, contrary to the assumptions implicit in recent critiques of ‘suffering slot’ anthropology, paying attention to the workings of power does not preclude ontological comparison. Through a comparison of the different kinds of visibility sought by patients and doctors in the public hospital, I argue that the question of power re-surfaces in relation to the mutually entangled infrastructures required to realise those different projects.

Keywords

Ethnography, infrastructure, power, suffering, technology

The woman was lying on her front, the hard contours of her bones visible through papery flesh. The whole of her lower back and right hip were covered in white padded bandages. She looked like she was unconscious but the nurse assured me she was not. As the doctor and nurses got to work peeling off the bandages she made muffled groans into the pillow. The nurses and doctor laughed together and joked as they worked. The smell intensified. As the first bandage was removed the severity of the wounds became clear. I stared in dumb shock. The wounds were leaking with pus. As the second bandage was removed it revealed half a hipbone, startling white against yellow flesh. I felt nauseous and dizzy. The nurse turned to look at me. ‘Go and sit in the office’, she said firmly.

Later, she explained what I had seen: a bedsore. The pressure from lying in one place had cut off the blood supply, leaving the tissues to rot away. The nurses didn’t have enough manpower to turn every patient by themselves. They relied on family guardians. ‘The family was told that she needed to be turned every two hours’, the nurse told me, ‘but for whatever reason they did not do it.’ She was

angry that the family had let the pressure sore fester. But when I asked how long it takes a sore like that to develop she looked at the desk and replied that the patient would have to be left untended for an entire day for it to get that bad, then became defiant as she exclaimed that they were expected to work in impossible conditions without enough nurses or doctors or the most basic equipment. Pressure sores that lead to septicaemia, she told me, are one of the leading causes of death on the medical ward.

Why was I so unprepared for the flesh, blood, and bone that, I should have known, would be ubiquitous on a medical ward in one of Papua New Guinea's struggling public hospitals? The truth is that I had thought about flesh, blood, and bone in terms of different cultural understandings of the body, disease, and kinship, but I had not anticipated the shame and outrage I would feel looking at the bare body of a woman I did not know, whose body was, literally, falling apart because there was no one there, in the middle of a provincial-level hospital, to simply turn her over. I was not, as may already be obvious, trained in medical anthropology. When I started reading Byron Good's *Belief, Rationality and Experience* my supervisor snorted, 'You don't want to get into all that stuff, do you?' That put an end to that. So what was I doing on the medical ward of a hospital in Papua New Guinea at all?

Good question. The answer is that I had joined a PhD programme fresh out of my undergraduate degree and I still thought it was all about being clever. I had done well in my undergraduate degree at Cambridge, largely off the back of actually reading *The Gender of the Gift*, properly, about four times. It had blown my mind. After three years of power/colonialism/modernity (this was the late 1990s, early 2000s), this extraordinary account of persons and bodies that do not cohere as individual units, that extend in space and time, that wear relationships on their skin, or conceal other persons within them, and its absolute grounding in careful, detailed ethnography gave me a new reason to be an anthropologist. Historically, anthropology had moved from a focus on the cultural other to processes of colonisation, globalisation, and power, and the suffering they engender (Robbins 2013). My educational trajectory had moved in reverse, from a focus on global interconnections mediated by power to the appreciation of deep cultural difference. My PhD application to study state power in Egypt was casually thrown aside. I was on my way to Melanesia.

‘Why don’t you go to a hospital?’ Marilyn Strathern suggested when I told her that traditional village fieldwork was not for me. I was going to bring STS to Melanesia; I was going to study experts, knowledge, technologies, and institutions; I was going (like all my peers) to transform anthropology. A Papua New Guinean hospital: I loved it! The goal, entirely theoretically conceived, was to examine the relationships between persons and technologies that shape both ‘Melanesian’ and ‘biomedical’ bodies in a Papua New Guinean hospital. What happens, I asked, if we extend the analytic language of assemblages and human–nonhuman relations from STS to kinship, and the analytic language of gift exchange and relationality from Melanesian anthropology to biomedicine?

This happens: the shame of being tactfully dismissed because my poorly concealed distress was distracting those who could save lives. For that was what everyone standing around Bed 8 – relatives and medical practitioners alike – was trying to do. And they were trying to do it under conditions of impossibility, in which the basic tenets of biomedical knowledge could not be held stable. In which diagnoses were uncertain, technologies were unreliable, and crucial drugs were unavailable.

These are the conditions of living and working in an institution that has been designed and yet is unable to operate as an exclusive realm of biomedical knowledge and authority. They are conditions that have emerged out of a history of biomedicine, science, and colonialism in Papua New Guinea, which are perpetuated by the politics of international development aid and the vertical programmes of global health. What was the response of my supervisor to my first field report, which described the lack of capacity for making a diagnosis in the hospital? ‘But people might just say the lack of diagnosis is wholly because of a lack of resources. How would you respond to this kind of reductionist explanation?’ Feeling scorned, I took this to mean that anything that can be explained by a lack of resources is essentially uninteresting (this may have been a misreading of the comment, but I doubt it). And yet there she was, a woman in terrible pain, who would die soon after her bandages were changed, and whose impending death seemed entirely explicable by a serious lack of resources.

So this is where the naïve, twenty-three-year-old, fieldwork novice me was: armed with a theoretical toolkit for the comparison of different bodily ontologies, yet faced with the urgency of my informants’ attempts to transform sick bodies and reduce suffering in the context of global inequality and biomedical failure. Comparison or power: this seemed to be the choice. Criticism of

recent Melanesian anthropology, with its intentional reification of cultural difference, resounded in my ears. In a context of physical suffering, poverty, and inequality a focus on cultural comparison seemed ashamedly apolitical. After all, as Paul Farmer (2004) has taught us, ‘culture’ can too easily become an apology for structural violence.

By virtue of the contexts in which we work, it is impossible for medical anthropologists to ignore physical and mental affliction and the questions about health inequalities that they give rise to. My ambitious readings in anthropological theory (ontology this, epistemology that) were clearly not up to the task of analysing ethnography from a place where social and physical survival are precarious and where possibilities for living are entangled with postcolonial institutions of biomedicine and the state. For when I looked at that woman’s bare hip bone protruding through rotting flesh, I knew that what I was looking at was power. And power is always in time. It is always happening. It is not a theory, or a model, or a lens, or a perspective. What is it again?

This is where my newfound convictions yet again came unstuck. After reading many of the excellent anthropological accounts of global health that have been published in recent years, many of them coming out of Africa, it started to seem like my account would simply document another instance of the same phenomena. We already know the way power works in relation to the globalisation of biomedicine, how it is experienced, and its effects. We know how inequalities are perpetuated through the structural sedimentation of discursive constellations. We know that biological bodies have become objects of governance and repositories of value. We know that attempts to govern health at the level of the individual and the population generate spaces of exclusion, neglect, and invisibility. And we know that these processes of power generate suffering. There might be differences in the ways in which people experience these power relationships, in the affective and relational trajectories of lives that are ‘lived out and endured’ in the context of larger systems and policies (Biehl and Petryna 2013, 11), but the nature of the relationships themselves appears to be universal.

Who can argue with suffering? One reaction by anthropologists to the self-avowedly critical approaches that have emerged out the anthropology of global health has been to take apart the second half of the power/suffering equation. Christians in Papua New Guinea, Robbins (2013, 459) argues, do not experience their economic and political marginalisation in terms of suffering: ‘[T]hey

were struggling, working to construct a liveable world on the other side of their experiences of contact and colonialism – experiences that made their previous way of life appear to them hopelessly inadequate.’ They were working to create good in their lives, and were doing so in highly particular ways. Yet in framing his argument around the need to resuscitate anthropology’s interest in deep cultural difference, the question of power is cast aside, seemingly forgotten, left for another kind of ‘suffering slot’ anthropology. ‘But are people able to realise the different versions of the good that they seek? And what happens when they can’t?’ I asked myself as I read Robbins’s article.

I am reminded again of the debates that raged around the publication of *The Gender of the Gift* in the 1980s and 1990s when Marilyn Strathern (1988) contended that women in Papua New Guinea do not experience relationships with men as exploitation. Strathern was accused of taking an unfeminist position because her suggestion that women are not ‘exploited’ when they are exchanged between men was taken to imply that she did not think power and domination characterise relationships between men and women at all. But are comparison and politics really opposed? Does ‘deep’ cultural comparison have to be apolitical? Does a focus on power belie cultural comparison?

In line with Robbins’s own account of Urapmin Pentecostal Christians, the patients I knew in Madang Hospital probably would not recognise an account of their experience of hospital biomedicine that was couched in the language of suffering. Indeed what struck me were people’s efforts to engage with biomedical technologies. Like the Urapmin, the patients I knew were not defeated by their apparent abandonment by kin and state alike. Instead, through their engagements with hospital technologies they sought new ways of compelling kin, doctors, and politicians to ‘see’ them.

Invited into the nurses’ office to hand over the chest x-ray he had carried back from the x-ray unit, the patient nervously whipped the film out of the envelope and held it up to the light as the doctors do on ward rounds, pointing to the dark parts where he presumed his *sik* (sickness) had been pictured. ‘It’s a good picture!’ he exclaimed, before the nurses told him he had it wrong and the dark bits were where his *sik* was not. Another patient shyly handed over the five-year-old clinic book that she had wrapped in white plastic, carefully preserving entries she could not read in the hope they might prompt the doctor to admit and treat her in the ward. ‘That doctor gave me the *ibeka* [spinach-like green leaves]’, another patient whispered to me triumphantly, ‘He saw me and felt

sorry. He bought them in the market for thirty *toea*. I am a good patient so he bought them for me.’ ‘I can’t know if the doctor will help me’, the old man said, wincing as he swallowed his daily regimen of pills. ‘This morning he came into the ward but he didn’t look at us, he just walked past. I just have to follow him and take my medicines.’

Whether in relation to filling in clinic books and forms; having an x-ray, ultrasound scan, or blood sample taken; or taking medicines, patients were convinced there was a right way to appear – if they engage with those technologies and present themselves in the correct form, the doctor will treat them. I have come to think of these experiments in bureaucratic or biomedical visibility as an exercise in the tapping, or drawing out, of biomedical powers from the Papua New Guinean doctors who had gained access to them. By objectifying themselves in forms that doctors *had* to see, patients sought to compel doctors to recognise a relationship with them and to act on their behalf. In medical anthropology we largely encounter objectification as a form of power that controls the world by stabilising it, making it ready for intervention. Yet here the objectification of oneself was engaged as a way of forcing a relationship on another person. A relationship, even a deeply unequal one, is a basis of mutual recognition from which to affect and be affected by others. For the patients that I knew, power inhered in this capacity to extract a response from others.

In Madang Hospital two kinds of objectification were practiced simultaneously. Doctors sought to render bodies visible so as to identify, know, and control the biological truths they contained. Patients sought to render their bodies visible in new ways so as to compel doctors to care. I suggest we might consider these two modes of objectification as two modes of power, two ways in which people imagine they might impinge on the actions of others. Back to comparison then. ‘Exploitation’ or ‘suffering’ may not fit our ethnographic material, but this does not mean the concept of power is defunct altogether, so long as we recognise it may not always take the form of control and domination that we expect.

Beyond the intrinsic interestingness of such a comparison, what was really striking in Madang Hospital was that both ways of impinging on the actions of others repeatedly failed. Bodies remained opaque and diseases invisible. Doctors seemed impervious to patients’ attempts to entice them into relationships of mutual recognition. Bodies continued to deteriorate, lives continued to be lost. Through their attempts at self-objectification and their scrutiny of doctors’ responses, patients

might seek to know themselves as a particular kind of person – one whose body bears the traces of one's relationships. In striving to see inside and diagnose a diseased body, doctors might seek to know themselves as autonomous experts. Yet rarely is either set of hopes realised. Understanding that failure requires attention to the historical relationships that constitute people's attempts to make their version of 'the good'. In Madang Hospital both diagnosing disease and compelling relationships involve engagements with broken morgues, x-ray machines that are short of fluids, hospital kitchens that cannot provide food, medicines that cannot be consumed without food, wards without enough nurses, a landscape without roads on which relatives might travel to donate blood, and laboratories without reagents. These hospital infrastructures are inadequate for projects of knowing disease and compelling relationships alike, although they are largely a historical product of the former.

Where does all this leave medical anthropology theory? The sheer brutality of the inequality and deprivation that we encounter makes it impossible for medical anthropologists grappling with issues of global health to put questions of power aside in favour of 'deep' cultural comparison. This is why both medical anthropologists and anthropologists of development continue to identify closely with an applied anthropology agenda. And yet it has also led to the sustaining of a boundary between medical and social/cultural anthropology that is counterproductive (see my PhD supervisor's comments referred to earlier). The anthropology of global health presents a challenge to all anthropologists to keep what is at stake for those they study at the very heart of their endeavour. But it does not preclude comparison. After that first day in Madang Hospital I continued to be interested in the radically different projects of improvement and transformation that people pursued in the hospital. But what really motivated me was the question of how those radically different projects had become socially and materially entangled in a single institution, and the implications of that entanglement for the lives it was possible to save and to live.

About the author

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